DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/24/14

PRINTED: 12/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445246	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON CITY HEALTH AND REHAB CENTER	283 W BROADWAY BLVD JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Supervisor, on December 8, 2013 at and 2:00 p.m. confirmed the following corridor doors failed to close to a positive latch: 1. Door to resident room 115 2. Door to resident room 618	K 018	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K018 Door to room 115 will be repaired by 12/27/13. Door to room 618 had the knob set replaced on Sunday, 12/8/13. Corridor fire door by room 402 will be repaired by 12/27/13 so that it closes with a positive latch. A total facility check was performed by Maintenance on 12/24/13 with no other doors found that did not close and latch. All fire doors and corridor doors will be placed on a weekly and monthly checklist for positive close and latch. The results of these checks, and any corrective actions, will be reviewed in the monthly Facility QAA	1/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dalma Vento	Administrator	12/24/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 3. Corridor fire door by room 400 These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 018	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.*	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined four (4) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Supervisor, on December 8, 2013 at 1:20 p.m. confirmed an unsealed penetration in the sleeve over the fire door by room 402. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 029	K029 Unsealed penetration in the sleeve over the Fire Door at Room 402 was sealed with Fire Rated Caulk on 12/11/13. A total facility check was performed by Maintenance of all fire walls for unsealed penetrations on 12/11/13 with no other penetrations found. Maintenance will do a monthly review of all firewalls to ensure that all penetrations are properly sealed . The results of these checks, and any corrective actions, will be reviewed in the monthly Facility QAA	1/23/14
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062	K062 400 Hall resident room privacy curtains that were closed and bunched up by the sprinkler heads will be moved so that they do not obstruct the sprinkler heads on starting on 12/23/13 and will be completed before 1/23/14. Holiday decorations in the dining room that obstruct the sprinklers will be removed /	1/23/14

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K 062	Continued From page 2 continuously maintained In reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and record review, It was determined the facility failed to ensure sprinkler heads were not obstructed. The findings include: Observation and interview with the maintenance Supervisor, on December 8, 2013 between 9:30 a.m. and 11:45 a.m. confirmed the sprinkler heads in the following locations were obstructed: 1. The 400 hall resident rooms were obstructed by the privacy curtains that were closed and bunched up next to the sprinkler head. 2. Holiday decorations attached to the ceiling in the dining room obstructed sprinkler heads, 3. Holiday decorations covered the sprinkler head above the resident bed in room 609. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 062	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K062 (continued) replaced 18" from and not obstructing sprinkler heads by 1/03/14 . Holiday decoration on the ceiling in room 609 was removed ceiling on 12/9/13. Checks will be made of other privacy curtains to determine if any additional sprinkler heads are obstructed, and corrections made, by 12/20/13. All other holiday decorations were checked for obstruction with sprinkler heads on 12/13/13 with no other obstructions found. All resident rooms were checked for holiday decorations obstructing sprinkler heads on 12/13/13 with no other obstructions found. Monthly room checks will continue to ensure that curtains are gathered away from sprinkler heads.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	All staff will be in-serviced by Maintenance by 1/13/14 on the proper placement of decorations in the facility. Maintenance will do checks for proper placement of all decorations in the facility. The results of these checks, and any corrective actions, will be reviewed in the monthly Facility QAA	

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K 066	Continued From page 3 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined smoking areas were provided with metal containers with self-closing cover devices (NFPA 101, 19.7.4 (4)). The findings include: Observation and interview with the Maintenance Supervisor, on December 8, 2013 at 10:20 p.m. confirmed two (2) of two (2) smoking areas had plastic trash receptacles that were overflowing with paper trash and cigarette butts. Both smoking areas were completely littered with several hundred cigarette butts along with paper trash on the ground. Interview with the Maintenance Supervisor revealed this has been a recurring problem. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 066	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K066 Smoking area was cleared of all cigarette butts on the ground, paper on ground removed and plastic receptacles emptied on 12/23/13. All staff will be in-serviced by 1/13/14 on proper use of ash trays and approved metal receptacles with lids for disposal of butts, not disposing of butts on the ground and keeping paper / trash clear of the smoking area.	1/23/14

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K 073 K 073 SS=F	Continued From page 4 NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure highly flammable combustible decorations were not used. The findings include: Observation and interview with the Maintenance Supervisor, on December 8, 2013 between 8:45 a.m. and at 2:00 p.m. confirmed the facility failed to treat holiday decorations throughout the corridors and dining room, and a quilt on the wall of the secured unit with fire retardant material. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 073 K 073	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K066 (continued) Smoking area will be placed on daily checks for proper use of metal receptacles, trash / cigarette butts on ground and trash receptacles free of butts by housekeeping and corrective actions made as indicated. The results of these checks, and any corrective actions, will be reviewed in the monthly facility QAA K073 All holiday decorations / quilt on the secure unit were either removed or treated with fire retardant material on 1/03/14. Maintenance and Activities will check all decorations in the facility for proper fire rating and either replace/remove or properly treat by 1/03/14. Maintenance will do monthly checks of all new decorations placed in the facility for proper fire rating, and either treat or remove as appropriate.	1/23/14
K 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075		

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K 075	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined soiled linen or trash receptacles exceeding 32 gallons in capacity were located in a room protected as hazardous when not attended (NFPA 110, 19.7.5.5). The findings include: Observation with the Maintenance Supervisor in the corridors on December 8, 2013 between 10:30 a.m. and 2:30 p.m. confirmed soiled linen containers exceeding 32 gallons capacity were left in the corridors unattended and not in use by the 100 hall shower room, by 414, and by 604. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 075	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K073 (continued) The results of these checks, and any corrective actions, will be reviewed in the monthly Facility QAA K-075 The soiled linen and trash receptacles will be stored in the soiled utility rooms when not in use. All staff will be in-serviced by maintenance by 1/13/14 on the proper storage of soiled linen/trash barrels when not in use. Linen barrel storage will be monitored daily by Maintenance/Housekeeping. Proper storage of soiled linen barrels will be reviewed monthly in the Facility QAA.	1/23/14
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical components were in accordance with the National Electric Code, NFPA 70. The findings include: 1. Observation and interview with the maintenance Supervisor on December 8, 2013 at 2:00 p.m. confirmed the electrical outlets in the corridor by rooms 114, 115, and 204 were not	K 147		

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K 147	Continued From page 6 attached inside the wall. 2. Observation and interview with the Maintenance Supervisor on December 8, 2013 at 9:00 a.m. confirmed the dining room had a 50-foot orange extension cord that was badly twisted which ran up the wall and between the ceiling tiles and grid for use with holiday decorations. 3. Observation and interview with the Maintenance Supervisor on December 8, 2013 at 1:30 p.m. confirmed an Oxygen concentrator was plugged into a power strip. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	K 147	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.* K147 Repairs to outlets in halls by rooms 114, 115, and 204 so that outlet boxes are not loose in the walls were completed by 12/13/13. Extension cord in dining room was removed on 12/9/13. Oxygen concentrator in room 404 was plugged into wall outlet on 12/8/13 and resident was moved to a room with more outlets. All hallways were checked for loose outlets on 12/20/13 Other activity areas were checked on 12/9/13 for extension cords that were damaged or improperly used. Other rooms will be checked for medical equipment plugged into power strips by 12/27/13 and any medical equipment plugged into wall outlets, hallways, activity areas, and rooms will be checked monthly to ensure outlets are in good working order, and extension cords and power strips are used properly and removed if damaged. Proper use of extension cords and power strips will be reviewed monthly in the Facility QAA.	1/23/14